DANSON

FIBRO-CYSTIC TUMOR

Compliments of A. W. Dawson

FIBRO-CYSTIC TUMOR

ATTACHED TO THE

FUNDUS OF THE UTERUS,

SEVENTEEN OTHER TUMORS IN THE CAVITY OF THE ABDOMEN,

With some Account of Abdominal Section for the Relief of Such and Similar Cases,

BY

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Taken from the LANCET AND OBSERVER of May, 1869.

FIBRO-CYSTIC TUMOR

ATTACHED TO THE

FUNDUS OF THE UTERUS,

SEVENTEEN OTHER TUMORS IN THE CAVITY OF THE ABDOMEN.

I saw this case with Drs Elstun and Langdon first in March, 1868. Dr. Langdon furnishes me with the following history:

"Mrs. L———, aged 35 years, of nervous lymphatic temperament, the mother of two children, the youngest six years old; was taken sick May 21st, 1867. Prior to this time she had enjoyed unusually good health, never having been ill for more than a day or two at a time. Had menstruated regularly and normally up to date of her sickness. She had just passed her menstrual period, which was perhaps a little scanty, lasting only about four days, her usual time being six, when she was taken sick, as before stated, May 21st, 1867, with intense and excruciating pain in the hypogastric region, with great irritability of the bladder. There was some frequency of the pulse, but no heat of skin indicating inflammatory action. A vaginal examination found the os uteri resting behind the symphysis pubis, the fundus slightly retroverted, the os patulous, readily admitting the tip of the finger, the pain not aggravated by pressure. The excessive pain was thought to be the result of congestion of the womb, with perhaps some slight displacement, and accordingly opiates were freely exhibited to control the pain, and hot fomentations used locally. Under this treatment she rapidly convalesced, the congestion of the womb seemed to relieve itself by the re-establishment of the menstrual flow, at about the end of the second or third week. At no time did she ever have anything amounting to a uterine hemorrhage.

After this attack she had her usual health, was at a celebration July 4th, and went about perfectly well, menstruating regularly, although, at times, there was a sense of soreness across the bowels. On October 7th, she had a second attack of this excrutiating pain in the uterine region. The symptoms were similar to the first attack, although there was more evidence of local inflammatory action, the womb was somewhat enlarged, and what seemed then to be the fundus, could be felt jutting above the pubis. There was also some induration about the region of the left ovary, and it was thought to be implicated in the inflammatory action. Hot fomentations externally and opiates by enema, promptly controlled the pain; about the end of the second week, the trouble seemed to relieve itself by a sanguineous discharge, similar to that which occurred in the first attack. On the 27th she was able to ride out, although the uterine enlargement and induration in the left ovarian region still existed.

The improvement in her condition was only temporary. Soon symptoms of high local inflammatory action came on with hot skin, rapid pulse, dry tongue, and scanty secretions. There was now great pain on pressure, and the tumor seemed to about the size of the womb at the third month of pregnancy, and the induration in the left ovarian region was much increased. There was now great sympathetic irritation of the stomach, with persistent vomiting, which produced considerable prostration, and the prognosis, at one time, seemed doubtful. On this account all remedies were administered by the rectum, with good results. When she was in this condition, Dr. Mendenhall saw the case in consultation November 8th, 1867. He concurred as to the local inflammatory nature of the case, and thought it was confined principally to the posterior wall of the uterus, and left broad ligament.

From this date there was a marked improvement in her condition, and by the latter part of the next month she was able to leave the bed, and sit up with a degree of comfort. and was at table to dinner Christmas day.

There was, however, more or less tenderness over the uterine region all the while, and at this time, the tumor projecting above the pubis, was as large as that of the fourth, or beginning of the fifth month of pregnancy, and the induration or tumor in the left ovarian region was the size of a small orange.

A steady and gradual improvement took place in her general health, and for a month or two she had her mesntrual flow; but with this improvement there was no diminution in the size of the enlargement; on the contrary there was a slow but gradual increase. Iodine was tried locally, as well as internally, in combination with iron, without the slightest advantage. At this time there was scanty secretion of the urine, with an edematous condition of the feet and limbs.

The growth of the tumor, now regarded as ovarian, had been such that in March, 1868, the measurement about the waist, just above the crest of the ilium, was thirty-five inches; from the anterior-superior spine of ilium to the umbillicus, on the one side eight inches, on the other, seven and a half.

At this time she was put upon a saturated solution of chlorat. potass. (ʒss to ʒi aquae); of this a dessert-spoonful was taken four times a day. This remedy is recommended by Mr. Craig of Air, Scotland, for the cure of ovarian dropsy.

In this case it seemed to hold the disease in check, and, at one time, there was a slight diminution in the size of the tumor as shown by measurement. The urinary secretion was greatly increased, and the effusion about the feet and legs nearly removed. The remedy is well worthy a trial in all similar cases.

The tumor continuing to enlarge, and as *fluctuation* was evident, a trocar and canula was thrust into it June 21st, 1868, but failing to reach the sack, no fluid was obtained. This tapping produced no unpleasant symptoms, but as the tumor constantly increased in size, the abdominal measurement reaching 45 inches, its great weight dragging down and pressing upon other organs producing a feeling of distention, with difficulty of breathing, and a thousand aches and pains, made life itself a burden.

Relief was sought in an operation for the removal of the tumor December 17th, 1868, Dr. W. W. Dawson of Cincinnati, operating, assisted by Drs. Mussey, Carson, Kearns, Elstun and others. The patient survived the operation some twenty hours."

Believing this to be essentially ovarian disease, I began the operation, but the knife soon revealed my mistake, and developed one of the most remarkable cases to be found in the annals of surgery, in fact, I have no where found its duplicate.

I made an incision from the umbillicus to the pubes, but finding the tumor large and dense, and the adhesions numerous, I extended it about three inches upwards. The tumor was about nine inches in diameter, and before attempting its evacuation I broke up the adhesions between it and the omentum and the abdominal walls. In elevating the mass to get at the pedicle, its walls gave way at one point, and about one gallon of serum escaped. The pedicle was one inch and a half long, and one inch and a quarter in diameter, and sprung directly from the fundus of the uterus; it was ligated by a double ligature. A heavy membrane attached the tumor to the right broad ligament; this was also secured by ligation. After removing this large mass, another of the same character was found lying in the right illiac fossa, and extending up into the lumbar region. It was about ten inches long and four inches in diameter, and tapered toward each extremity. This tumor literally had no attachment except a mere filmy, adventitious membrane, which extended over to the left broad ligament. After lifting this from its bed, seventeen others, varying in size from a hazel-nut to a goose-egg were removed. Some of them were attached to the omentum, some to the messentery, others to the walls of the abdomen, whilst two or three small ones were detached from the walls of the pelvis, All of them except one, which was firmly adherent to the omentum, were held in position by the same delicate false membranes. The reader can scarcely conceive of the fragile character of these membranes, and the little force which it required to sever them.

The tumors were essentially fibrous, the principal one with two others next in size, were fibro-cystic, the remainder were solid fibrous masses without cavities. The cavity in the great tumor was large, rough and irregular, and contained besides the gallon of fluid already spoken of, *a large quantity of ragged, half decomposed fibrine.* It was this fluid which gave me the fluctuation, an element in the diagnosis which had much weight in leading me to believe the disease to be ovarian. Hanging from the wall of one of the medium sized tumors was a hydatid, about three quarters of an inch in diameter. The cavity in great tumor was hardly cystic in the true sense of the word, but in the two smaller ones the cavities were essentially so, being lined by a smooth membrane, and filled with serum.

AUTOPSY.

CONDITION OF THE UTERUS.—After the death of the patient, the uterus was examined and found to be *normal in shape and size, and its cavity of the usual depth.* The tumor was attached to its fundus, and although the abdominal cavity was strewn with false membranes, this organ was free from any connection with them. I had, by exploration previous to the operation, assured myself of its position. I had found it at proper depth from the vulva, but crowded against the pubis by the tumor, and the sound gave two inches and a half as the length of its cavity. I would again state the remarkable fact *that the uterus was in a normal condition in size, shape and position*, although this immense tumor was continuous with, and attached to its fundus.

The reasons which induced me to regard this as ovarian disease.

1. *The size of the abdomen, and its gradual enlargement.*—Uterine growths seldom certainly reach an abdominal circumference of forty-five inches.

2. *The varied consistence of the swelling.*—The density at one point being greater than at another, in this respect resembling a multilocular ovarian tumor, where some of the cysts are filled with serum, others with jelly-like matter, others, again, with material still more dense, and in which the walls and septae are often thick and fleshy.

3. *Fluctuation* was always evident over parts of the abdominal surface, and was distinct through the vagina at the time when I first saw the case in March, and again in June, though at my last examination, a few days previous to the operation, I cou'd not detect through the vagina the peculiar impulse so well marked on the two previous occasions.

4. *Tapping.*—Although no fluid followed the trochar I felt confident that it was present. If a cavity filled with jelly-like substance had been entered, there would of course be no discharge. Often the cavities of multilocular growth are occupied by material too dense to flow through a canula. The post mortem showed that the instrument entered the solid portion of the tumor, but did not proceed far enough to reach the fluid.

5. *There had been no uterine hemorrhage.*—Menstruation had been conparatively undisturbed: This is the case where but one ova-

ry is affected. In uterine tumors, especially the mural and sub mucus varieties, the menstruation is greatly disordered, and uterine hemorrhage very frequent.

6. *Uterus.*—The position of the uterus was normal, except that the tumor, resting on the brim of the pelvis, had crowded it to the symphysis. This latter fact accounted for the immobility of the organ. The sound showed that there was *no increased length of the uterine cavity*, nor was there the early hardness which usually characterizes fibroids. Tubular souffle was absent. In this connection I may, however, say that the uterus, so far as its position is concerned, is unreliable as an element of diagnosis, both in ovarian and in uterine diseases; in either it may be in reach, or it may be lifted out of the vagina by the ascending tumor. *Even the depth of its cavity is indecisive.* Dr. C. F. H. Routh (Obstetrical Transactions, London, 1867,) reports two cases of ovarian disease, in one of which the uterine cavity measured six inches, in the other the depth was greater. Such facts show the difficulty, aye, the almost impossibility, of making in some cases a definite diagnosis.

There was but one point in the history of this case which suggested uterine involvement, and that was the median position of the tumor when first noticed. This was far from conclusive in the absence of all other characteristic signs, and especially so when I remembered that Dr. Bright (New Sydenham Society, 1859,) had said, that "the growth of this tumor (ovarian) is on some occasions so unperceived, that, though it might have originated on one side, it has already risen into the pubic, and even the umbilical region; and when the medical man is first consulted, its *lateral origin is with difficulty ascertained.*" Again, the ovaries are not firmly attached, the tumor often by mere force of gravity falls over into the pelvis, and may be there found in the median line when first observed.

What was the origin of these seventeen floating tumors? Rokitansky (*Pathological Anatomy, Vol. II, page* 222,) in discussing somewhat the same question, remarks: "We must here advert to a circumstance that is not of very rare occurrence, viz: we sometimes find a fibroid tumor in the pelvic cavity, and generally in Douglas' space without any further connection with the uterus, except by means of cellular cords or laminæ of new formation (false membranes), which pass from the tumor to the uterus and its appendages, to the pelvic walls, the rectum, etc. The question

presents itself, which is the original point of development of such fibroid tumors? They are generally tumors which have originally been developed under the uterine peritoneum, and, after having become entangled in a network of pseudo-membranous formations resulting from the peritonitis they have excited, are gradually detached from the uterus. Occasionally, however, they may have been developed within the false membranes themselves, which is the more probable, if we consider that the new tissue, as it proceeds from the uterine peritoneum, participates in the character of the subserous uterine cellular tissue. Hence, it is extremely likely that we really see very small fibroid tumors occasionally develop in this new tissue. To these fibroid tumors, the loose fibrous concretions, which are sometimes found in the pelvic cavity, are allied; they must be considered as fibroid tumors of the uterus, which have become detached in consequence of atrophy of peduncle."

This theory of Rokitansky will not account for the seventeen floating fibroids in my case, for the uterus was in a state of positive integrity, except at its fundus, to which the pedicle of the great fibro-cystic was attached. This great tumor may, however, have been proliferous, may have thrown off the lesser ones found in the abdominal cavity. This is rendered probable from the fact, that its surface was in some parts nodulated, and to it also were attached, by adventitious tissue, two or three small tumors.

Upon this subject Grailey Hewitt (*Diseases of Women, page* 550,) says: "A very curious feature in the history of these sub-peritoneal tumors is, that the pedicle is sometimes torn across, and the mass entirely seperated from the uterus, while the tumor itself becomes fixed to, and grows on some other part of the peritoneal surface. This transplantation of fibroid tumors has been observed in several cases. It appears to be produced by the tumor becoming adherent elsewhere; the pedicle becomes stretched in consequence of the motions of the uterus and intestines, and finally gives way.

Here it must be mentioned that fibroid growths are sometimes found connected with the peritoneum in the vicinity of the uterus, which have an origin independent of the uterus altogether. These must not be confounded with transported fibroid tumors of the uterus. It appears that growths in no way distinguishable by their microscopic characters from uterine fibroid tumors, may originate in the position above indicated. Mr. Paget observes,

that they are probably limited to those parts in which fibrous and smooth muscular tissue, like that of the uterus, extends; that is to say, the utero-rectal and utero-vesical folds of the broad ligament. Muscular fibres lying under the peritoneum covering the uterus, broad ligaments and ovaries, and serving certain important purposes in the process of ovulation, exist in the positions mentioned by Mr. Paget, as those in which fibroid tumors may originate. It is likely that the fibroid tumors of the ovaries, which are extremely rare, belong really to the category now under consideration; and that they originate in the muscular layer under the peritoneum, in the neighborhood of the ovary. I believe it will serve a useful purpose, if we denominate these tumors as *peri-uterine fibroid tumors*, in order to distinguish them from those actually and primarily connected with the uterus."

This solution of Mr. Paget does not apply in the case under consideration, for one of these tumors, a beautiful one the size and shape of a medium pear, was attached to the omentum. Here certainly "fibrous and smooth muscular tissue, like that of the uterus," did not extend: by transplantation, not, however, from the uterus, but from the parent tumor it may have gained its position.

In the *London Obstetrieal Society's Transactions for* 1866, Dr. Bathurst Woodman reports a case (post-mortem) where there were about fifteen tumors altogether. Some "were internal, some in the walls of the uterus, and some growing out of them into the peritoneal cavity." Here we have in the same uterus the three varieties of uterine tumors, the "internal," the *submucus*, from which come the uterine polypii; those "in the walls," *the interstitial*, which give us the fibroma; those "growing out into the peritoneal cavity" are the *subperitoneal* tumors which are occasionally attached by a pedicle.

After thus closing the history of my case, I propose giving somewhat of the experience of surgeons on the two following points:

1. *Where errors in diagnosis have been made.*

2. *Where fibroids of the uterus or fibro-cystic tumors pedunculated to the uterus have been diagnosed, and their removal attempted or completed.*

One of the most recent cases which I have seen reported, may be found in the *Medical Record, New York, June* 1, 1868, *page* 160. The case was presented to the New York Pathological Society, by

Dr. James B. Cutter, of Newark. It was of two years standing; abdomen as large as at full term; history in reference to whether it appeared first in the illiac region or in the median line, unsatisfactory; fluctuation thought to have been detected; uterus in normal position; uterine sound introduced five inches; surface of the tumor symmetrical. It was diagnosed ovarian by Drs. Cutter, Ward, Peaslee and Emmet, the latter gentleman thought there was also a fibroid of the uterus, he based his opinion on the fact, that the uterine cavity was of so great depth. Dr. Peaslee, when he examined the case, was only able to introduce the uterine sound three inches, and it was only after the death of the patient that he learned that Dr. Emmet had reached a depth of five inches. On learning this, he is quoted as having remarked that "if Dr. Cutter had told him that the uterine sound had been passed to the distance of five inches, the question of the existence of a uterine tumor would have been cleared up in his mind at once." These two distinguished gentlemen, Drs. Peaslee and Emmet must have forgotten Dr. Routh's ovarian cases already referred to in this paper, or they would not have regarded great length of the uterine canal as positive evidence of uterine tumor. These cases both had a uterine-cavity depth of six inches. Dr. Cutter found the tumor solid, vascular and attached to the fundus of the uterus. Almost the whole of the latter organ and both ovaries, in a state of disease, were removed. The patient died in ten hours.

Mr. Spencer Wells with his characteristic frankness gives, in the 43d. Vol., page 128, of the *Dublin Quarterly Journal*, a case of *Cystic Degeneration of the Kidney*, which he believed to be ovarian. His knife revealed the nature of the affection.

Dr. Routh details (*London Obstetrical Society Proceedings*, 1867,) a case of *fibro cystic tumor of the uterus*, mistaken for ovarian, the operation abandoned, death in thirty-four hours. All the usual symptoms of uterine disease were absent. Sir Wm. Furgusson and Dr. Savage endorsed the diagnosis of Dr. Routh, but Dr. Greenhalgh dissented. He believed that the uterus was involved. The post-mortem showed that he was correct.

In his work (Diseases of the Ovaries) Spencer Wells gives two cases of *fibro cystic disease of the uterus*, which he supposed to be ovarian dropsy, and in which he made an abdominal section. Death resulted in both.

Dr. W. L. Atlee, in the *American Journal of the Medical Sciences* for April, 1845, gives a case which he diagnosed as ovarian, but which proved to be a fibrous tumor attached to the uterus, by a pedicle two inches long and one and a half inches in diameter. Dr. A. removed the tumor by gastrotomy. His patient recovered.

Dr. J. Deane, (*Boston Medical and Surgical Journal*, October 11, 1848.) reports a case, where, instead of finding an enlarged ovary, he encountered a "tumor which embraced the entire left half of the uterus." The operation was abandoned, and the patient recovered. He says: "the propriety of abandoning the operation was fully justified by subsequent events, for the constitutional disturbances that ensued were severe and threatening. These were due to two distinct causes, the *inspiration of chloroform* and structural injury." This charge against chloroform will surprise and amuse the practitioner of to-day.

Dr. John M. Boyd (*American Journal of the Medical Sciences*, 1857,) reports a case of "extirpation of the uterus and its appendages," in which, previous to the operation, "the diagnosis was not well made out." Patient recovered.

That distinguished surgeon, Prof. Chas. A. Pope, in the St. Louis *Medical and Surgical Journal*, 1866, records a case in which by abdominal incision, he removed the uterus and both ovaries. In conclusion he says, "in reviewing the case, I must say that had I foreseen its exact nature and difficulties I certainly would not have operated. But how impossible is it, even for the most experienced, to foretell all the complications of such and similar cases." Death in three hours.

Dr. Alexander Dunlap, the eminent Ohio Ovariotomist, in his report on Ovariotomy, (*Transactions of the Ohio State Medical Society*, 1868,) gives a case in which the tumor was attached to the fallopian tubes and uterus. The patient died from hemorrhage. In defining a rule for the guidance of the surgeon in these abdominal growths, Dr. Dunlap says: "I would reject all solid tumors as unsafe for an operation, on account of the uncercainty as to the size of the pedicle."

Dr. E. Krakowizer performed gastrotomy for what he conceived to be "a simple ovarian tumor, about the size of a child's head, two years old." The uterus was in proper position, and mobile, and its cavity of normal length, but he fonnd the tumor occupying its posterior wall. He ligated both fallopian tubes, and

then divided the uterus near the cervix, with the ecraseur. The ecraseur was three-quarters of an hour in accomplishing its work, "but as soon as the stump was liberated, the whole field of the operation was deluged with blood." Death in less than 24 hours. (*Midical Record, N. Y.*, 1867.)

Henry Lee, in his "Analysis of cases of Ovariotomy," *Medico-Chirurgical Transactions*, London, 1851, makes the following record:

In 1823, Mr. John Lizars, of Edinburgh, made a long incision through the abdominal parietes of a woman, aged 27, who in the opinion of some of the most experienced physicians in that city, was afflicted with ovarian disease, but the symptoms were produced by obesity, and distension of the intestines, and there was no ovarian cyst or tumor found present to remove on laying open the abdomen. This patient did not die from the operation. * * In 1826, Mr· Lizars repeated the operation, but he encountered a vascular tumor, (uterine no doubt, W. W. D.,) which could not be removed. * * In 1827, Dr. Granville repeated the operation, but there was no ovarian tumor to remove. Some time after this, it was proposed again to perform the operation, but the consent of the patient could not be obtained, and she died some years after under the care of Dr. Scott of Stratton street. Both ovaria were sound, and the enlargement arose from a great vascular tumor imbedded in the walls of the uterus."

From the *Biennial Retrospect of the Sydenham Society* I take the following cases: "In one of five cases of Ovariotomy reported by Mr. Nunnelly, the tumor after removal was examined by Dr. Gailey Hewitt and Mr. Wells. They reported that it was uterine, although Mr. Nunnelly says that all who were present at the operation were of opinion that it was ovarian. The patient recovered."

In the North Staffordshire Infirmary "a fibro-cystic tumor of the uterus was operated upon in mistake for ovarian disease. It it is stated, that the uterus felt normal by the vagina. The removal of the tumor was not attempted. The patient died in fifty-three hours of peritonitis."

"A uterine tumor removed by mistake for a tumor of the ovary, by T. Holmes, (*Pathol. Trans., XVII.*, 1866). The tumor was of large size, and had grown very rapidly, and had yielded fluid on tapping. The patient died shortly after the operation."

Where fibroids of the uterus or fibro-cystic tumors pedunculated to the uterus have been diagnosed, and their removal attempted or completed.

The *Med. Times and Gazette*, for Feb. 27, 1869, says: "M. Koeberle

of Strasburg, communicated to the Academie de Medicine a case of fibro-cystic tumor of the uterus weighing 14½ kellogrammes, which he removed in August, 1868. The case, he said, was especially remarkable on account of the exactitude of the diagnosis, and the exceptional difficulty of the operation, notwithstanding which, complete recovery took place. Fibro-cystic tumors of the uterus, he remarks, have been rarely observed, and their diagnosis has been, to the present time, regarded as impossible. There are but fourteen on record, two of which were only recognized after death, and had not given rise to surgical interference. M. Koeberle's case is in fact the only one in which the diagnosis has been determined prior to an operation. The others were mistaken for ovarian disease. The cases, then, upon which operations have been performed, are twelve in number. In four instances the operation was left unfinished, and three of the patients died, one, in whom only a simple exploratory incision had been made, recovering. In eight cases the operation was completed, and four of these recovered, including the case now recorded, and four terminated fatally."

Dr. James B. Cutter (*Medical Record*, New York, Oct. 15, 1868,) gives the history, diagnosis of and operation upon a fibroma of the uterus. All the symptoms characterizing this form of disease were present. The uterus close to the neck was removed by the ecraseur, but little blood was lost. Death on the third day from exhaustion.

Dr. Wm. Warren Greene cut down on a fibro-mural tumor of the uterus in a woman clamorous for an operation. The adhesions to the pelvic walls were so great, that no attempt at the extraction of the tumor was made; the incision was closed. The patient survived the operation, and was in better health afterward, although the size of the uterus was not diminished. (*Boston Med. and Surg. Journal, Jan.*, 1868).

Spencer Wells in 1863 attempted to remove a large submucus fibrous tumor of the uterus, by "a sort of Cæsarian section"—"Gastro-Hysterotomy," as he termed it. The tumor weighed 17 pounds. Death in four hours.

Dr. Thomas Wood reports in the *Cincinnati Lancet and Observer*, for January, 1867, an operation which he performed for fibrous enlargement of the uterus. The case bid fair for recovery, but finally succumbed.

In 1844, Dr. W. L. Atlee diagnosed and excised a fibroma of the uterus by the "large peritoneal section." The tumor was found to be almost sessile on the right side of the uterus. The patient had a rapid and permanent recovery. *American Journal of the Medical Sciences*, 1844.

Dr. Kimball, of Lowell, Mass., operated in 1853 for the removal of a fibrous tumor; operation abandoned; death in twelve days, (*American Journal of the Medical Sciences.*)

In this review of cases I have not included those collected by the learned and accomplished Dr. H. R. Storer, and so well presented by him in the *Amer. Journ. of the Med. Sciences*, for 1866, and in the *New York Med. Record*, Vol. I., page 385. Dr. S. has given thirty-one cases in which the uterus was extirpated for non-malignant disease. Dr. Thos. Woods' case, already referred to, increases the number to thirty-two. Of these twenty-five died. Some of these cases were attacked as uterine, others, the larger number, however, were encountered in the belief that the disease was ovarian.

DAWSON

ON

FIBROUS

AND

FIBRO-CYSTIC TUMORS

OF THE

UTERUS.

CINCINNATI:
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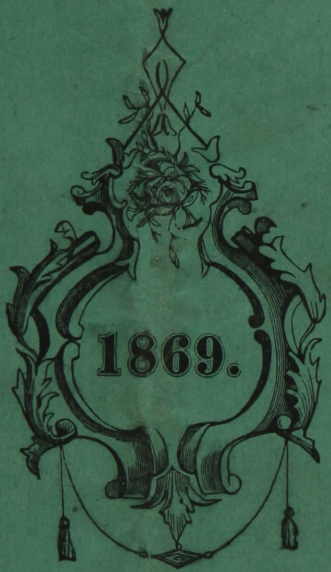
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